Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN635HOS	A. BUILDING _____ B. WING _____	C 03/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON TAHOE REGIONAL MEDICAL CENTER	1600 MEDICAL PARKWAY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 8/19/10 and finalized on 8/30/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital. Complaint #NV00025835 was unsubstantiated. The investigation was re-initiated on 1/4/11 at the request of the complainant. The investigation was conducted on 1/4/11 and finalized on 3/21/11, in accordance with Nevada Administrative Code, Chapter 449, Hospital. Complaint #NV 00025835 was unsubstantiated based on review of clinical records, interviews of family members and friends of the patient, interviews of clinical staff in the facility and, former physicians. The allegations of quality of care and neglect were both unsubstantiated. Clinical records from the Hospital #1 and the facility were reviewed . Clinical records were also reviewed at the facility. All physicians who cared for the patient were interviewed except the last surgeon who performed a consult on 6/21/10. This physician was unavailable for interview. Interviews with physicians included: Physicians #1, the original surgeon who treated the patient from Calendar year 2003 to 2010 at Hospital #1. Physician #2, the emergency room specialist who treated the patient when he was brought by his family to the facility on 6/18/10. Physician #3, the facility's hospitalist who admitted the patient to the hospital for inpatient care.	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 000	Continued From page 1 Physician #4, the gastroenterologist who performed th endocsopic exam of the patient in the facility on 6/19/10. Interviews with all nursing staff identified as having provided care to the patient were conducted as well as the director of quality assurance, the nurse manager of the nursing unit where the patient was cared for and the manager of case management /discharge planning. The following facility policy, "Hourly Patient Rounding" was reviewed. No regulatory deficiencies were identified. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		